Treatment Readiness For Drug Users

USAID-funded Drug Demand Reduction Program in Uzbekistan, Tajikistan, and the Ferghana Valley Region of Kyrgyzstan

DDRP BEST PRACTICE COLLECTION

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DDRP best practice collection series includes:

- **Treatment Readiness for Drug Users**
- Drug Demand Reduction Program
- "Sister to Sister"
- Youth Power Centers
- Drug Demand Reduction Education and Referral of Migrants
- Unique Identifier Code
- Drug free Treatment and Rehabilitation for Drug Users
- Drug free Public Social Spaces
- "Break the Cycle"
- Positive Youth Development

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INTRODUCTION AND OVERVIEW

What is the DDRP?

The USAID-funded Drug Demand Reduction Program (DDRP) aims to address social problems among vulnerable population involved in (or at risk of involvement in) drug use in Central Asia. DDRP activities in Uzbekistan, Tajikistan, and the Ferghana Valley Region of Kyrgyzstan are a response to the dramatic rise in opiate injection in the region.

The term "drug demand reduction" is used to describe policies or programs directed toward reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions [1]. The countries covered under this program have experienced significant increases in opiate consumption due to geography and recent socio-political events including the collapse of the Soviet Union and the Afghan conflict. Heroin transiting through these countries has created epidemics of drug use, undermining already fragile economies and threatening to overwhelm health systems with HIV. This has also occurred in other nearby former Soviet republics. DDRP's mission is to engage all levels of society in reducing demand for heroin and other opiates. The program began in 2002 and will cease in 2007.

The Drug Demand Reduction Program involves a network of leading international organizations active in HIV prevention and drug demand reduction in the region.

The key components of the DDRP include:

- educating target populations on drug-related issues;
- promoting healthy lifestyles;
- providing access to alternative occupational and leisure activities;
- assisting in solving social problems;
- supporting the development of pragmatic drug demand-reduction strategies at national and local levels.

This Treatment Readiness for Drug Users Model is one of ten developed under DDRP for replication and contribution to HIV and drug demand reduction policy and program development in the Central Asian region.

What is the DDRP Treatment Readiness for Drug Users Model?

The DDRP implemented 10 treatment readiness projects in Kyrgyzstan, Tajikistan and Uzbekistan. These projects were targeted at drug users, including sex working drug users and active injecting drug using youth. Eight of these sites were visited to capture the experience of these projects as they were implemented. The lessons learned were distilled to produce this model.

The DDRP treatment readiness projects aimed to decrease injecting drug use and HIV transmission by motivating active injecting drug users to undertake treatment and to stop using drugs. The treatment readiness projects worked closely with the DDRP drug free treatment and rehabilitation projects (The Drug Free Treatment and Rehabilitation Model is another publication in this series.)

Central to reducing the demand for drugs is the motivation of drug users to undertake treatment. However, individuals are often ambivalent about ceasing drug use. The first stage of treatment readiness thus involves the assessment of an individual's preparedness to change. Through repeated contacts, individuals move towards a decision to stop drug use and seek treatment.

Regional seminar of David McVinney for consultants, Tashkent, Uzbekistan

A range of approaches characterized the various DDRP treatment readiness projects. Common to all projects was a client-centered approach, based on reinforcing the client's psychological strengths. This approach encouraged clients to develop an individual path out of drug use. Projects thus aimed to create a positive environment in which changes aimed at abstinence from drug use could be initiated and supported. Motivational interviewing was the main technique used to assist client decision-making. Services to the target group were provided by counselors appropriately trained in drug dependency. Treatment readiness services were provided both through outreach and at fixed sites alongside other services to intravenous drug users (IDUs). All steps on the path from drug use to abstinence were regarded as indicators of success both for individual clients and for the project. The following were examples of client progress towards abstinence:

- a reduction in daily dosage of drugs;
- a reduction in frequency of drug use;
- regular participation in the DDRP treatment readiness activities;
- referral to the DDRP drug free treatment and rehabilitation program.

The approaches featured further in this document provide examples of the range of services that should be regarded as complementing the central aims of the DDRP Treatment Readiness for Drug Users Model. The provision of additional services depends on the resources available to an organization, and these services should not interfere with the client-centered approach of this DDRP model. The 12-step program is one example of additional services that can successfully complement the treatment readiness approach.

Individuals seek treatment for a range of reasons. However, barriers to treatment include financial constraints, fear of registration as a drug user, and perceived low efficacy of available treatment services [2]. The DDRP offered integration of treatment readiness with free, anonymous and evidence-based treatment services to injecting drug users in an effort to minimize the barriers to their entering treatment and stopping drug use.

This model focuses on building the heroin user's attachments to counseling staff and volunteers, peer groups and activity components, and it allows heroin/opiate users to "bottom out" or experience their crisis inside the program rather than outside on their own, where health and social risks are far greater.

BENEFITS OF THE TREATMENT READINESS FOR DRUG USERS MODEL

DDRP treatment readiness approach was first of its kind in Central Asia

The DDRP focus on treatment was seen as both a unique and positive contribution to drug demand reduction and HIV prevention at all sites visited. Funded organizations suggested most projects related to injecting drug use in the region focused on needle exchange only rather than on encouraging individuals to get into treatment programs and on abstinence from drug use. Local professionals too strongly praised the DDRP as the main donor program in the region to move beyond risk reduction for injecting drug users.

Treatment readiness interventions targeted hard to reach populations

Treatment readiness projects aimed to decrease injecting drug use and HIV transmission through targeting drug users, including sex working drug users and youth. The projects demonstrated the effectiveness of outreach-based programs in reaching and motivating injecting drug users to change their risk behaviors.

Injecting drug users in Central Asia are difficult to reach: fear of arrest and harassment drives injecting drug users to avoid all contact with police and medical institutions. DDRP treatment readiness projects actively developed relationships with police, government and health administrations to minimize harassment of injecting drug users seeking treatment.

Treatment readiness interventions led to significant benefits for individuals and co-dependents

Motivational interviewing, supported by credible, relevant education and information, formed the backbone of treatment readiness projects. Education was undertaken through outreach, drop-in centers and outpatient services, and targeted both drug users and their significant others such as family and

spouses (referred to here as co-dependents). As an indicator of the popularity of treatment readiness activities, most organizations visited in the development of this model stated that they had underestimated the client demand for treatment readiness services in the project planning phase.

Treatment readiness projects demonstrated the value of anonymous referral networks

Treatment readiness assumes the availability of treatment and rehabilitation.

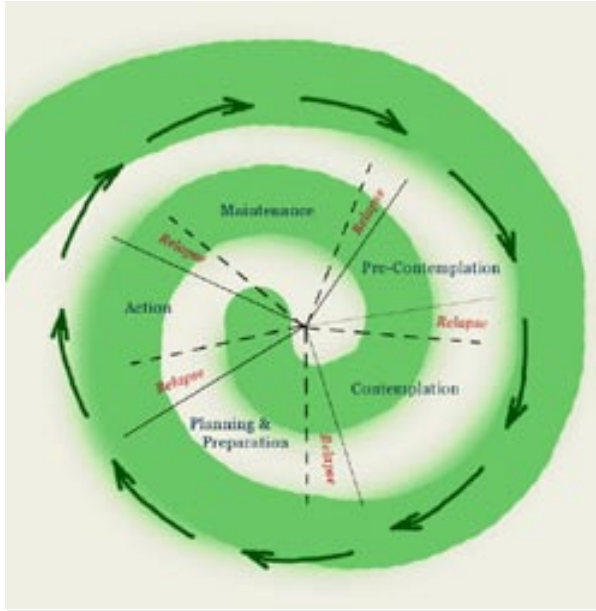
Close relationships between DDRP treatment readiness projects and DDRP-funded drug free treatment and rehabilitation services were noted in all organizations. Treatment readiness projects drew together drug demand and risk reduction activities into a unified approach within a defined geographical region. The projects demonstrated the value of linking drug treatment readiness, HIV prevention, drug treatment and rehabilitation in an active and anonymous referral network. An individual could obtain appropriate services and then be assisted by program staff to move to other appropriate programs.

LITERATURE REVIEW

This is a brief literature review covering issues of treatment readiness and drug demand reduction. It is an overview of theoretical assumptions underpinning the individual projects within the DDRP Treatment Readiness for Drug Users Model.

Prochaska and DiClemente "Stages of Change" model

James Prochaska and Carlo DiClemente's five-stage model is generally used to assess an individual's readiness to change their drug use behavior. The model suggests behavior change a process rather than a single event, determined by an individual's degree of motivation [3].



Prochaska and DiClemente "Stages of Change" model

The "Stages of Change" Model describes five stages of change. An individual moves from being uninterested, unaware or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change (determination/preparation). Genuine, determined action is then taken (action) and, over time, the new behavior is maintained (maintenance). Relapses are almost inevitable and become part of the process of working toward life-long change (relapse).

Motivation and outreach

Prochaska and DiClemente's "Stages of Change" model underpins the motivational interviewing approach [4]. The "Stages of Change" model allows health care professionals to determine which intervention strategy to use with each individual, depending on which stage the individual is at. The ultimate goal is to assist the individual to make effective changes and to sustain enhancements over time [5].

The motivational interviewing counseling approach assumes that many individuals are ambivalent toward changing their drug use behavior. The aim of motivational interviewing is to enhance motivation to change through allowing the individual to convince themselves of the need for change. The motivational interviewer explores the positive and negative results of drug use, provides an opportunity to explore specific concerns, communicates understanding and aims to assist the client in deciding if behavior change is necessary.

There is strong evidence of increased rates of entry into drug treatment as a result of outreach interventions [6]. Outreach is also effective in achieving behavioral changes including: reductions in the frequency of injection, a decrease in the sharing of needles and other injecting equipment, fewer group injection settings, a reduction in the number of sex partners as well as in the frequency of risky sex, and increased needle disinfection and condom use [7].

Why do injecting drug users seek treatment?

Drug users' willingness to seek help is likely to be mediated not only through perceptions of their drug use as a problem, but also through their understanding of particular services. Research suggests that drug users have poor information about possible sources of help [8,9]. The attraction of services is further influenced by factors such as previous treatment experiences, word of mouth, and the ability of a service to meet the particular needs of the individual [10,11].

Several factors have been found to influence an individual's decision to seek treatment. These include social support from families, partners and health professionals [12], legal problems [13], and physical health problems

[14]. HIV risk behaviors, and being HIV positive have also been found to be associated with entering treatment [15]. In addition, individuals who have previously had treatment are more likely to enter treatment [16].

The frequency of injection and level of heroin use in the preceding 30 days [17] and uncontrolled drug lifestyle are both associated with treatment seeking behavior [18,19]. Several factors have been found not to influence treatment-seeking behavior. These include the length of time of drug use, age, race, ethnicity and education [20].

Barriers to treatment entry

A number of barriers may prevent individuals from entering treatment. These include personal factors, systemic factors and program factors. Personal factors include difficulties with family arrangements [20], social stigma associated with being labeled a drug user [21], and the perceived lack of severity of drug use [22]. Systemic factors include poor information about possible sources of help and treatment options [23], lack of treatment availability [24]. Program factors include costs of drug treatment, loss of time and income as well as lack of confidence in the quality and style of the treatment offered [25,26,27,28].

In a study of barriers to drug treatment among injecting drug users in two Russian cities [29], three main barriers to treatment were identified. These were financial constraints, fear of registration as a drug user, and perceived low efficacy of available treatment services. Registration as a drug user was associated with loss of employment, breaches in confidentiality, and stigma. Some participants did not think that drug treatment services could respond appropriately and effectively to their treatment needs. Recommendations included reducing the financial burdens of drug treatment, minimizing the stigma associated with drug user registration, and a shift away from a strictly medical treatment approach.

INDIVIDUAL PROJECT DESCRIPTIONS

This section provides an overview of each of the seven sites reviewed during the DDRP Treatment Readiness for Drug Users Model development process. (For a complete list of all DDRP-funded treatment readiness projects please refer to the List of organizations implementing treatment readiness projects.)

NGO Healthy Generation, Djalal Abad, Kyrgyzstan

Djalal Abad is a former Silk Road city. It is the administrative and economic center of Djalal Abad province in southwestern Kyrgyzstan, with a population of about 105,000. It is situated at the northeastern end of the Ferghana Valley next to the Uzbek border. The unofficial rate of unemployment in Djalal Abad is approximately 70 percent. Soviet era light manufacturing has ceased to function, as has most of the agricultural sector, leaving the local market as the single source of cash income. As a consequence every second household has at least one male between the ages of 25 and 55 working in Russia or Kazakhstan.

The NGO Healthy Generation implemented the DDRP treatment readiness project in Djalal Abad. The organization began work at the Djalal Abad AIDS Center, initially without external funding. In 2003, the organization was registered and received independent funding in response to an overwhelming demand from drug users and their families. NGO Healthy Generation targeted active drug users, and in an average month, the project recruited approximately 20 new clients. The project tried to maintain contact with most clients 5-6 times per week, with a focus on the many large and small *yamy*, places where drug users gather, across Djalal Abad.

NGO Healthy Generation undertook motivational work with clients aimed at reducing drug use, preventing HIV, improving medical assistance to injecting drug users and improving social conditions for injecting drug users. The NGO also worked with people living with HIV/AIDS on the development of partnerships with provincial government and non-government service providers, and implemented a Global Fund-funded outreach HIV risk reduction project targeting injecting drug users.

During the training, NGO Healthy Generation, Djalal Abad, Kyrgyzstan

The NGO placed a high priority on the work with co-dependents in its treatment readiness project. This generally consisted of careful contact via telephone or in a cafe: most frequently, parents initiated contact. New drug injecting clients were very wary and required a long process of trust building, discussions with friends and telephone — only discussions prior to initial face-to-face contact. Clients who were 40 years old or older were noted to be especially resistant to interventions. Notably, many older clients did not seek abstinence from drug use, but rather wanted to regain control and reduce their drug intake.

Motivation was the focus of individual outreach discussions with drug users including explanations of available treatments and provision of information and education materials. Outreach workers also aimed to motivate drug users to attend apartment-based seminars. In addition to street-based outreach, outreach seminars were held in co-dependents' apartments: group seminars were held at least once a week and were dedicated to themes such as healthy alternatives, smoking, HIV prevention and testing and drug use. They were usually attended by at least 15 people. Seminars were delivered in apartments, following an episode of theft from the office. It is worth noting that the difficulties associated with ensuring the security of property and equipment are entirely expected among organizations engaged in low threshold treatment readiness projects with injecting drug users. The decision to conduct seminars in individual apartments was a successful resolution to the problem of maintaining the security of property while also delivering effective client education. This response also demonstrated the flexibility of the DDRP.

Coffee and sweets were regarded as critical to attract individuals to participate in outreach discussions and treatment readiness seminars. Auricular acupuncture was also provided during outreach seminars and was shown to be cost-effective and medically effective. Psychosocial counseling for people living with HIV/AIDS was also provided. No legal services were offered to clients, but the project provided individual advocacy for individuals caught with drugs.

Healthy Generation also provided regular training seminars for students in the local medical school. The NGO operated a telephone hotline open 24 hours, and linked the hotline to outreach services by car to visit clients if necessary. Evenings and the period before public holidays were the most common times for telephone contact.

In 2005, 52 drug users were referred for drug treatment from Healthy Generation: two people were referred to the Djalal Abad government run narcology service and 50 people to the anonymous and free local DDRP-funded drug free treatment and rehabilitation project run by NGO Diaron. Some individuals preferred commercial services. The project also had strong links with the Djalal Abad AIDS Center to which individuals were referred for HIV counseling and testing and, if found to be HIV positive, HIV services.

NGO Healthy Generation employed a drug treatment specialist, director, psychotherapist, assistant and three outreach workers on a full- or part-time basis.

NGO Parents Against Drugs, Osh, Kyrgyzstan

Osh is an ancient Silk Road city in the Ferghana Valley of southern Kyrgyzstan near the border with Uzbekistan. It has an ethnically mixed population of about 214,000 made up of Kyrgyz, Uzbeks and Tajiks. Osh, the second largest city in Kyrgyzstan, is regarded as a more religious and conservative city than Bishkek, the national capital. Osh has several very large outdoor markets that draw customers from a broad area. Osh also lies on major drug routes from Afghanistan and has one of the highest rates of injecting drug use, commercial sex work and HIV infection in Kyrgyzstan. In Osh city in April 2006, there were 1,133 registered injecting drug users, and 1,550 in Osh province. Of reported HIV cases, 90 percent were among injecting drug users.

Auricular acupuncture therapy, NGO Parent Against Drugs, Osh, Kyrgyzstan

The NGO Parents Against Drugs had previous experience with risk reduction projects funded by United Nations Development Program and the Soros Foundation. In 2004, when DDRP funding was obtained, the project had ready outreach workers and networks among drug users. In addition, the Osh province administration provided the NGO with premises, which were renovated with client assistance. Before the DDRP project, staff had felt frustrated by an inability to refer people for drug treatment and rehabilitation. The Parents Against Drugs project was also closely associated with the Osh Province Drug Treatment Center and offered the opportunity to refer people for treatment and rehabilitation. Parents Against Drugs was also conducting a risk reduction project for injecting drug users with funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The NGO's motivation services were based around GFATM-funded trust points, where drug users exchanged syringes and obtained information. The organization reported that Global Fund and DDRP services were a very effective mixture of services for attracting clients.

The average age of clients was great than 30 years. The age of clients had increased progressively over a 10-year period. There were suggestions that many of the older age group were peripherally involved in drug distribution and became dependent after trying easily accessible narcotics. Anonymous surveillance revealed that 14 percent were HIV positive and 27 percent were Hepatitis C positive. Between 2004 and mid 2006, 348 individuals were referred to the Drug Treatment Center from the project. In addition, the number of individuals treated at the Osh Center doubled.

Parents Against Drugs provided services including individual counseling, motivational interviewing, motivational discussions, group psychotherapy, individual psychotherapy, auricular acupuncture, HIV services, and counseling for codependents. Clients were referred to the AIDS Center for HIV testing, or to one of two DDRP-funded drug free treatment and rehabilitation services in Osh, based on the client's expressed preferences. These organizations were NGO Musaada or the Osh Narcology Center. Counselors maintained relationships with clients, from initial street-based contacts, through motivation, treatment, and beyond rehabilitation in a case management-like system.

Auricular acupuncture seminar, NGO Parent Against Drugs, Osh, Kyrgyzstan

Parents Against Drugs employed a director, an assistant, a drug treatment specialist, a psychologist, and 12 social workers (outreach workers). The social workers provided both GFATM and DDRP services.

Ferghana Province Narcological Dispensary, Uzbekistan

Ferghana is a city of 183,000 people, 420 kilometers east of Tashkent. Ferghana is the capital of Ferghana province located in the Ferghana Valley near the border with Kyrgyzstan. It is one of the largest cities in Uzbekistan, where high unemployment, sex work and drug use were noted.

The Ferghana Province Narcological Dispensary opened the Drug Crisis Center and provided services and a venue where drug users could receive anonymous psychological and occupational therapy. The center also worked with community leaders to increase their understanding of the causes and treatment of drug addiction. The project's relationships with police were enhanced through seminars aimed at discouraging the harassment of drug users. Police regularly referred clients to the Ferghana Center. Most clients were males averaging 25 years old. Some had recently started smoking heroin, while others had injected for 20 years. Project staff noted a marked tendency toward older and wealthier clients referring themselves for treatment readiness services. These included clients from conservative intact rural households in their 40s, who had recently tried heroin for the first time out of curiosity.

Auricular acupuncture therapy session, Ferghana Province Narcological Dispensary, Uzbekistan

The Ferghana Center provided center-based and outreach services. The center was open between 12:00 and 18:00, six days a week, while outreach workers provided services seven days a week. Outreach consisted of motivational interviewing and encouragement to visit the center. Center-based outpatient services included motivational interviewing, group work with co-dependents, occupational therapy, counseling, art therapy, massage, auricular acupuncture, meditation, and relaxation therapy. In addition, medical services were offered for other medical issues. Although food had initially been provided as an incentive to encourage client attendance, the increasing affluence of recent clients suggested food provision had become less important. Voluntary HIV testing was encouraged, accompanied by pre- and post-test counseling. Staff reported many clients feared testing.

The project employed a director, psychotherapist, psychologist, occupational therapist and teacher, outreach workers and art therapist on a full- or part-time basis.

NGO Family and Children, Tashkent, Uzbekistan

Tashkent, the capital of Uzbekistan, is a city of 2 million people located on major drug routes from Afghanistan with high rates of sex work and injecting drug use. Tashkent attracts many young unskilled workers seeking to escape the high rural unemployment of Uzbek villages. NGO Family and Children was one of the few local organizations providing services to commercial sex workers in Tashkent.

Family and Children's treatment readiness project aimed to motivate drug using commercial sex workers in Tashkent city toward drug treatment. In two months of operations, it reached 50 people between the ages of 15 and 45, with an average age of 25 years. Most clients were literate and spoke both Russian and Uzbek. While the great majority of clients were female, the project also attracted some male sex workers.

Family and Children provided a range of services including outreach, seminars, office-based services and onward referrals. Outreach services were provided from sunset onwards at tochki, sites of street-based sex work. Information about sexually transmitted infections, HIV and drug use accompanied motivational interviewing. Surveys of commercial sex workers in target areas by outreach workers formed the basis for seminars. Each seminar was delivered as a no-cost lunch, at 14:00 on Saturday. Invitations were distributed by outreach workers in advance. Each seminar featured specific themes such as drug demand reduction, sexually transmitted infections, and HIV prevention. Interactive teaching methods were used, including pre- and post-seminar knowledge testing and the collection of participant feedback. The seminars aimed to increase knowledge, increase trust, identify new tochki and attract new clients to the project. Overall, the seminars revealed a poor understanding of drug dependence among commercial sex workers and provided information on this issue in Tashkent. Office-based services included auricular acupuncture and sexual health and psychological counseling. Referrals were primarily directed to the Tashkent AIDS Center for HIV testing and to the Tashkent Republican Drug Treatment Center for drug treatment, which included the option of entering the DDRP-funded Drug Free Treatment and Rehabilitation service at the Center.

Family and Children conducted regular seminars for police. In addition, all outreach workers carried identification and made agreements with local police commanders before undertaking outreach in any area. Nevertheless, difficulties were reported with raids on tochki, particularly common before public holidays and visits by foreign dignitaries. The project collaborated with the local city administration in drug demand reduction and HIV prevention projects.

Staff included a director, a drug treatment specialist, a sexual health medical specialist, a psychologist, and four outreach workers. In addition, informal leaders among target groups integrated into the project in the capacity of volunteers.

NGO Izis, Tashkent, Uzbekistan

NGO Izis opened in 2003. The target group for Izis was injecting drug users in central Tashkent between the ages of 18 and 30. All staff had previously worked on other donor funded projects. A group of professionals started the project in response to the lack of drop-in style services in Tashkent. Izis' services included motivational interviewing, counseling, outreach, self-help group, auricular acupuncture, phytotherapy (traditional herbal medicine), and participation in sports. These were provided through outreach and at NGO office, which was open between 08:00 and 17:00 each day. Onward referrals for drug treatment were most frequently directed to the Tashkent Republican Drug Treatment Center, where the Izis psychologist also worked. Several clients who had completed courses of drug rehabilitation in the Republican Drug Treatment Center continued to receive relapse prevention services at NGO Izis. The NGO employed a director, five outreach workers, two counselors, a psychologist and a drug treatment specialist on a full- or part-time basis.


Group counseling at the NGO Izis, Tashkent, Uzbekistan

NGO DINA, Khujand, Tajikistan

Khujand is Tajikistan's second largest city and the administrative center of Sughd province. This city of 149,000 is situated on the Syrdarya River in the south of the Ferghana Valley. The treatment readiness project in Khujand was conducted by the NGO DINA. DINA was organized in 1998 and was successful in attracting the support of government and international donor organizations. Working together, DINA and the Sughd province administration created an

integrated NGO-government system for the prevention, treatment and access to medical care for populations most vulnerable to HIV/AIDS, including street children, homeless, drug users, commercial sex workers and people living with HIV/AIDS. In addition, DINA has extensive experience with donors and international NGOs including USAID, OSI, AFEW, Accord, International Research and Exchange Board, Pharmacists without Borders (Pharmaciens sans Frontiers), Mercy Corps Tajikistan, United Nations Office on Drug and Crime, United Nations Development Program, PSI and the Organization for Security and Co-operation in Europe. DINA's services at the time of the review included a 10-bed work therapy and rehabilitation center in the nearby Palass village, a counseling center, education center, and information and analysis center engaged in advocacy, media and analytical work. The DINA rehabilitation service is documented in the DDRP Drug Free Treatment and Rehabilitation of Drug Users Model.

The DINA treatment readiness project opened a drop-in center in Khujand in 2004. The center aimed to motivate injecting drug users to seek treatment. The DINA drop-in center was located in the 27th micro-district at the edge of Khujand.

The DINA drop-in center provided services for people between the ages of 18 to 50. The Center was open 24 hours a day, seven days a week. The center emphasized the importance of creating conditions to attract clients. Thus, services included eight beds for clients needing shelter or those who decided to go through withdrawal without medical assistance, showers, laundry facilities and a place to rest. The drop-in center also provided auricular acupuncture, motivational interviewing and consultations with specialists and aimed at maintaining the resilience of individuals who had completed courses of drug treatment rehabilitation. The drop-in center was well integrated into a broad network of medical and social services in Khujand, including anonymous referral to province drug treatment and HIV testing networks.

NGO MOST, Dushanbe, Tajikistan

Dushanbe is the capital of Tajikistan with a population of 562,000. The city was badly damaged during the Civil War in 1992-97. The DDRP treatment readiness project in Dushanbe was implemented by NGO MOST. MOST was started in 2004 by former injecting drug users who met during drug rehabilitation. The NGO's office is located at the edge of central Dushanbe and drew many of its clients from its immediate densely populated neighborhood as well as from all over Dushanbe due to its location next to a main road and several marshrutka routes. In late 2005, MOST obtained initial donor support in the form of DDRP funding to provide low threshold treatment readiness services.

Seminar with drug users, NGO MOST, Dushanbe, Tajikistan

The MOST project targeted injecting drug users and their co-dependents. Client ages ranged from 20 to 43. Among the target group were a number of former prisoners. MOST had only a small number of female clients. While the NGO had not experienced specific difficulties with police, staff suggested there was a significant fear of the police among clients. MOST had not formally lobbied local senior police, although junior police had been encouraged to refer drug users.

MOST aimed to provide a range of services through a drop-in center. These included individual counseling for injecting drug users and co-dependents, individual psychological counseling and legal services. The organization believed there was limited scope in running formal groups for active drug users, as the lifestyle of many drug users meant organizing group counseling in advance was impossible. However, a 12-step self-help group met every Sunday, and a group for codependents started to meet regularly after being initiated by the female psychologist. In addition to their own drop-in center, the personnel of organization provided counseling sessions in the Republican Narcological Center and AIDS Center.

The NGO actively referred individuals to the most appropriate services. It advocated on behalf of individuals to narcology clinics for access to pharmacological detoxification services. In addition, many clients were reportedly

unaware of their HIV status. MOST actively motivated individuals to undertake voluntary HIV testing, provided pre- and post-test counseling, and liaised with the AIDS Center to confirm individuals had attended for testing.

Eight staff provided services on a full- or part-time basis. These included a director, a psychologist, a lawyer, outreach workers and counselors.

LESSONS LEARNED

This section of the DDRP Treatment Readiness for Drug Users Model provides an overview of general recommendations and lessons learned from the reviewed DDRP projects. The information in this section serves two purposes: first, to provide a services description and second, to capture the best practices observed during the project process, which might serve as a guide in the Central Asia region. (The full detailed information for organizations seeking to implement the treatment readiness projects is described in the separate DDRP publication "DDRP Treatment Readiness Program Protocol")

DDRP Treatment Readiness manual's cover page

Location of treatment readiness facilities

The characteristics of the target group should be clearly defined to ensure effective project implementation and monitoring of outcomes.

A good understanding of the target city is important to reach the target population. Preferred locations were close to city centers, in areas of high population density, or easily accessible via public transport. This was noted in Dushanbe, Tashkent and Djalal Abad. In addition, offices or drop-in centers should take into consideration the location of gathering spots (known as yamy and tochki) where injecting drug users and commercial sex workers congregate as was noted in Osh and Tashkent. Many organizations were allocated premises by local city or health administrations. Services should not be located in residential buildings to avoid potential thefts and stigma. The minimum requirements to realistically deliver services should be considered.

Most projects were initially allocated premises in very poor condition and repairs were made with the assistance of clients. This was generally regarded as part of the therapeutic process. Further, most organizations underestimated the client demand in the project planning phase, and reported they would have sought larger premises to accommodate this level of service demand.

Partnerships

Injecting drug users present a difficult issue for local administrations, health services, police and mahallas. Local administrations may feel pressure from local residents, and the staff of these services may have negative stereotypes. Further, these organizations are in a position to actively help or hinder the operations of organizations providing treatment readiness services. Developing and maintaining positive personal relationships with their senior and junior representatives is imperative. Individuals and organizations with pre-existing contacts from previous employment, or previous projects, may be better placed to avoid difficulties. Strong relationships with other DDRP and non-DDRP projects were therefore crucial to organizations working in the treatment readiness field.

All organizations visited in the development of this Model either had previously administered grants or had donor-experienced staff. Several projects reported their DDRP services were significantly more attractive to clients if run concurrently with other donor projects. Organizations involved in needle exchange for injecting drug users are in close and constant contact with the target group. Close relationships with harm reduction organizations, in order to access clients, were regarded as important by all organizations reviewed. Close relationships with treatment and DDRP-funded rehabilitation services were noted in all organizations.

Advocacy and promotion

- *Roundtables*

Roundtables were regarded by all organizations as an important first step when launching a project or adding new components. Roundtables provided opportunities to gather senior representatives of local administration, health services, police, mass media and other donors to discuss projects and gain community support.

Discussion of working plans, Samarkand Branch of Uzbek Association on Reproductive Health, Uzbekistan

- *Educational seminars*

In addition to direct treatment readiness services, projects provided seminars to medical students, police and clients, with different drug-related themes appropriate to the target group each time. These seminars fulfilled both an advocacy and educational function. Seminars to police and the Ministry of Internal Affairs staff were regarded as an effective mechanism for building and maintaining relationships. This was noted in Ferghana and Tashkent. Several organizations had formally incorporated their work with high-risk groups into the HIV and drug control targets set by local administrations. This relationship with the local administration was regarded as an advocacy mechanism allowing otherwise socially controversial interventions to operate without major difficulty. Charismatic NGO leaders and senior staff were able both to inspire their colleagues and maintain relationships with local authorities. This appeared to be especially important in the early stages of newly funded projects

- *Initial project promotion*

Initial promotion was particularly important, especially for new NGOs. Television, particularly teletext services, was found to be an especially effective means of promotion in Djalal Abad, Kyrgyzstan. Newspapers and radio were regarded as less effective. Word of mouth through professional and injecting drug user networks and trust points was effective at all sites. Personal relationships with senior narcology and polyclinic staff, as well as participation in seminars with government and donor organizations, were regarded as assisting promotion. Printed leaflets glued to posts in markets where groups gathered were an effective low-cost means of promotion. Significant resources were required to take on consistent advocacy.

- *Parental advocacy*

Parents often expressed sincere gratitude for assistance. Several organizations noted that parents had directly contacted the local city administration and health administration to thank them for supporting DDRP-funded treatment readiness services. These organizations encouraged parents to contact local administrations directly to voice their appreciation for drug demand reduction interventions.

- *Individual legal advocacy*
  Most organizations did not provide legal services. However, in the case of NGO Healthy Generation in Djalal Abad for example, legal advocacy for individual clients was undertaken by the project director. Positive relationships with local police and government officials were seen as providing a foundation for individual legal advocacy.

Service delivery

- *Client demographics*
  Males were most common in all projects. Females were more inclined to use telephone services and thus preserve their anonymity. Anecdotal evidence suggests a consistent trend across many projects toward older clients. Curiosity associated with the appearance of the drug in a peer group was frequently reported by clients as the reason for trying the drug. Older users, especially long-term users were noted to be especially difficult to motivate, and many simply wished to undertake treatment to regain control over their drug intake.

- *Ethnic groups*
  Various ethnic groups including Roma were frequently associated with drug use and the drug trade by DDRP project staff and clients. Stereotypes related to specific ethnic groups were common across all sites and should be considered when discussing drug demand reduction with professional staff and local government representatives of local government, police, and health administrations. The veracity of these statements was impossible to determine during this review.

- *Stigma and co-dependency*
  Stigma and family attitudes to drug use are barriers to treatment readiness. In addition, several clients felt stigma was reinforced by local religious leaders' strong advocacy against drug use. Most organizations reported high numbers of clients referred by families for treatment readiness assistance. This was noted at all sites except Family and Children in Tashkent, where the primary target group was commercial sex workers. Family stigma was

especially strong in some regions. In Ferghana Valley, for example, stigmatization made it difficult to run support groups for codependents, as families did not wish to be recognized. Under those circumstances, group work with codependents was limited to family members only.

Wealthier families and those with a family member commanding respect (e.g. local political leaders, police commanders) may be especially likely to conceal the presence of a drug using family member, as it may result in social stigma affecting the entire family. NGO Healthy Generation reported an increased tendency for families with money to refer drug users. This was regarded as a "rich unreachable" population that would avoid all contact with services until problems become extreme after many years of drug use.

- *Literacy and language*
  Younger individuals, particularly under 25, were frequently less literate. Literacy and language should be considered when developing information, education and communication materials.

- *Demand for services*
  Most organizations reported they had underestimated the demand for services in their grants. The period preceding holidays was noted as an especially busy period for clients seeking assistance. NGO MOST in Dushanbe reported an unexpectedly large number of clients on New Years Day, suggesting clients did not wish to be alone on important holidays.

- *Food as an incentive for injecting drug users*
  Food and events were used by several organizations as an incentive to encourage participation in treatment readiness. In Tashkent, Family and Children provided seminars in cafes during the day. In Ferghana, lunch was offered twice weekly. In Djalal Abad, Healthy Generation provided sweets during street-based outreach and provided food at motivational seminars. In Osh, this was regarded as particularly important in the early stages of contact when clients required tangible incentives in exchange for engaging in conversation.

The following services were provided by DDRP treatment readiness projects:

- *Motivational interviewing*
  Motivational interviewing was regarded as central to treatment readiness at all sites. All organizations felt their staff could benefit from further training in this technique. All organizations described the difficulty in motivating injecting drug users.

- *Outreach*
  Outreach was the main contact mechanism for reaching and motivating current drug users at all sites surveyed. Outreach was the mechanism for motivating the target group to attend seminars in fixed locations and attend drop-in centers. Larger numbers of outreach workers were regarded as desirable at most sites. Pay for outreach workers was generally regarded as very low by local standards.

- *Drop-in centers*
  Drop-in centers were regarded as important. Clients at several sites expressed a wish for drop-in centers to be open 24 hours a day, seven days a week. DINA in Khujand provided an excellent example of how a drop-in center could function. It included showers, food, and laundry and sleeping facilities: all available 24 hours a day. In Djalal Abad, a drop-in center was regarded as a desirable addition to current services. In Ferghana, a range of treatment readiness services were provided on an outpatient basis. In Tashkent, clients suggested they would prefer a 24 hour drop-in center.

- *Office-based services*
  Not all services were provided through outreach. Services were provided in a number of settings including the apartments of co-dependents and at the project offices. Center-based services included motivational interviewing, anonymous phone counseling, individual and group counseling, legal support, meditation, auricular acupuncture, yoga, relaxation, massage, and non-drug related general medical services.

- *Referrals for voluntary HIV counseling and testing*
  At all sites, clients were encouraged to undertake voluntary HIV counseling and testing. Several sites reported widespread fear among clients of testing for HIV. Testing was supported by pre-test and post-test counseling through DDRP treatment readiness projects.

- *Protection from police pursuit*
  Client fear of police was very strong even where treatment readiness service provider organizations had developed good relationships with local police. At several sites, police raids on commercial sex work tochki were regarded as part of routine police work. At all sites, outreach workers carried identification, linking them to a project, and carrying the signatures of senior local figures (e.g. police commander, head of local government units) Agreement with local police commanders before going to new areas further assisted in preserving good relations and minimizing harassment. Strict rules about not bringing drugs onto the premises were seen as an additional mechanism for preventing potential difficulties.

- *Social assistance*
  Assistance with work, housing and legal issues in the longer term were important to offer as part of the initial motivation process. In Khujand, social services were provided to a broad range of vulnerable groups including street children, homeless people and students without requiring identification as an injecting drug user.

- *Availability of treatment*
  Treatment readiness implies the availability of treatment and rehabilitation. The cost of detoxification treatment was identified as a barrier at all sites visited. Close relationships with treatment and DDRP-funded rehabilitation services were noted in all organizations.

Training of staff and volunteers

Most outreach workers were former drug users, partners, or codependents, and several organizations had employed former drug users as professional staff. At NGO Parents Against Drugs, for example, volunteer outreach workers received

training in HIV/AIDS, overdose prevention and first aid, STI counseling, the Stages of Change model, motivational interviewing, auricular acupuncture, the DDRP Unique Identifier Code and how to work with codependents. All organizations felt further training in motivational interviewing would be of benefit.

Staff burnout was noted as a risk at most organizations. All organizations referred to the difficult nature of treatment readiness work with clients. Education to protect staff from the emotional burdens of complex client work was regarded as an essential element in training.

NGO Healthy Generation reported intensive sessions of 20 days were of most benefit in directly transferring knowledge to improving client care. Several organizations had staff that had conducted site visits to the Monar drug treatment program in Krakow, Poland. Monar was widely regarded among most programs as an ideal model to which Central Asian treatment readiness services should aspire, even while realistically acknowledging the many differences in social, political, and economic conditions.

Monitoring and evaluation

- *Use of the UIC*
  Most organizations sometime reported client fear of the Unique Identifier Code, or UIC, during street-based outreach. This resistance was particularly strong at the time of initial contact. Clients particularly feared outreach workers holding pieces of paper and asking them to make marks on that paper. Illiteracy was an additional complicating factor, particularly in Osh and Djalal Abad. NGO MOST in Dushanbe sdevoted significant discussion about how best to overcome client resistance. NGO MOST in Dushanbe suggested initial approaches to clients with the statement that they were "partners and colleagues in our project" had proved to be a more successful approach to requesting information from injecting drug users.

- *Internet and physical conditions influence monitoring and evaluation*
  The lack of safety and poor physical conditions may make use of a computer for monitoring and evaluation difficult.

REPLICATION

This section of the model provides some suggestions for replication.

The importance of good relations with the local administration, health administration and police may assist in obtaining free or highly subsidized premises and aid in avoiding potential difficulties.

- *NGO Healthy Generation, Djalal Abad, Kyrgyzstan*
  Healthy Generation suggested that a drop-in center, complete with sleeping and washing facilities would be a valuable addition to outreach-based motivation.

- *NGO Parents Against Drugs, Osh, Kyrgyzstan*
  Parents Against Drugs demonstrated the importance of sufficient funding for pharmacological detoxification to ensure rapid referral of motivated clients. Most local people, and particularly dependent drug users, could not afford the USD30-40 required for a 15-20 day course of detoxification medications.

- *Ferghana Province Narcological Dispensary, Ferghana, Uzbekistan*
  The Ferghana Province Narcological Dispensary provided motivation services on both an outpatient and outreach basis. The Ferghana Dispensary demonstrated the importance of trust-building and improving a client's self esteem in an environment of extreme stigmatization and fear.

- *NGO Family and Children, Tashkent, Uzbekistan*
  The experience of Family and Children showed the importance of excellent collaboration and ongoing advocacy with police, health and city administrations to allow service delivery to occur. In addition, the NGO had wished to employ a lawyer.

- *NGO DINA, Khujand, Tajikistan*
  DINA demonstrated successful integration of prevention, treatment readiness, detoxification and referral to treatment and rehabilitation. DINA further demonstrated the successful integration of donor funding, NGO advocacy, and government replication at a province-wide level.

- *NGO MOST, Dushanbe, Tajikistan*
  MOST demonstrated that successful grant recipients can attract and inspire other local projects. For example, the Boxing Federation in Dushanbe approached MOST for assistance with writing project plans and running joint projects. In 2006, CARITAS – Germany supported a large portion of this NGO's activity targeted at DDR.

GLOSSARY

Drop-in center: A drop-in center is a site that provides drug demand reduction services to a specific target group, such as individuals in at-risk groups, active drug users and commercial sex workers. While some drop in centers aim to facilitate social contact between clients and professional staff, other centers may offer at-risk individuals services such as food, washing and sleeping facilities. Drop-in centers for drug demand reduction generally aim to provide "low threshold services". That is, they have very open criteria and allow anyone who wishes to visit the center to do so.

Drug demand reduction: The term "drug demand reduction" is used to describe policies or programs directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions (the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988). The distribution of these narcotic drugs and psychotropic substances is forbidden by law or limited to medical and pharmaceutical channels [30].

Mahalla: Traditional Central Asian local neighborhood structure, with limited responsibilities for local affairs including family welfare and minor disputes.

Marshrutka: Minibus

Narcological dispensary: Drug and alcohol treatment clinic

Social workers: The term outreach worker and social worker are used interchangeably. Social work as an academic discipline is at an early stage of development in Central Asia, and most social workers have not completed degrees in the discipline.

Tochki: Locations at which drug dealing or commercial sex work transactions occur. Outreach workers will describe their work as "going out to tochki".

Yamy: Locations where drug users gather. In Russian, literally, "holes in the ground".

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